	FOR OHF USE				

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL

RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0042				II. CERTI	FICATION BY	AUTHORIZED FACILITY	OFFICER
	Address: Maple Lawn Health Center Address: 700 North Main Number County: Woodford	Eureka City	615 Zip	30 Code	State of and cer are true	f Illinois, for the tify to the best on accurate and o	contents of the accompany period from 01/01 of my knowledge and belief tomplete statements in accomplete statements of preparer (of Declaration of Decl	that the said contents ordance with
	Telephone Number: (309) 467-2337 IDPA ID Number: 370681536001	Fax # (309) 467-9097			is base	d on all informat	sentation or falsification of the punishable by fine and/o	ny knowledge. any information
	Date of Initial License for Current Owners: Type of Ownership:	1922			Officer or	(Signed)		(Date)
	X VOLUNTARY, NON-PROFIT X Charitable Corp.	PROPRIETARY Individual	GOVERN State	IMENTAL	of Provider	(Title)		
	Trust IRS Exemption Code 501 (c) 3	Partnership Corporation	Cou	nty		(Signed)	SEE ACCOUNTANTS' CO	OMPILATION REPORT (Date)
		"Sub-S" Corp. Limited Liability Co. Trust			Paid Preparer	(Print Name and Title)		
		Other				(Firm Name & Address)	Altschuler, Melvoin and G One South Wacker Drive, (312) 634-3400	Suite 800, Chicago, IL 60606 Fax # (312) 634-5518
	In the event there are further questions about th Name: Charles J. Fischer Please send copies of desk review and aud	Telephone Number: (312) 634-	-3400			ILLII 201 S	LTO: OFFICE OF HEALT NOIS DEPARTMENT OF F Grand Avenue East gfield, IL 62763-0001	H FINANCE

STATE OF ILLINOIS Page 2

Facil	ity Name & ID Numbe	er Maple Lawn	Health Center				# 0042424 Report Period Beginning: 01/01/02 Ending: 12/31/02
	III. STATISTICAI	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/co	ertification level(s) of	f care; enter number	of beds/bed days,			(Do not include bed-hold days in Section B.)
	(must agree v	with license). Date of	change in licensed b	eds	N/A		
				_			E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							None
	Beds at				Licensed		
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?
	Report Period	Level of C	Care	Report Period	Report Period		
							G. Do pages 3 & 4 include expenses for services or
1	89	Skilled (SNI	3)	89	32,485	1	investments not directly related to patient care?
2		· · · · · · · · · · · · · · · · · · ·	atric (SNF/PED)	-	52,100	2	YES X NO Non-allowable costs have been
3		Intermediat	`			3	eliminated in Schedule V, Column 7.
4		Intermediat	e/DD			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5	29	Sheltered Ca	are (SC)	29	10,585	5	YES NO X
6		ICF/DD 16 o	or Less			6	
							I. On what date did you start providing long term care at this location?
7	118	TOTALS		118	43,070	7	Date started 1922
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	the entire report per	iod.				YES Date NO X
	1	2	3	4	5		
	Level of Care		by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid					YES X NO If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified 13 and days of care provided 827
-	SNF	5,200	6,615	827	12,642	8	
9	SNF/PED					9	Medicare Intermediary Mutual of Omaha
	ICF	7,401	11,221		18,622	10	
	ICF/DD					11	IV. ACCOUNTING BASIS
	SC	1,577	8,706		10,283	12	MODIFIED
13	DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14	TOTALS	14,178	26,542	827	41,547	14	Is your fiscal year identical to your tax year? YES X NO
	C. Percent Occ	cupancy. (Column 5,	line 14 divided by to	tal licensed			Tax Year: 12/31/02 Fiscal Year: 12/31/02
		line 7, column 4.)	96.46%	_			* All facilities other than governmental must report on the accrual basis.
		•	•	-	SEE ACCOUNTAI	NTS' C	OMPILATION REPORT

				STATE OF ILI	LINOIS					Page 3	
Facility Name & ID Number	Maple Lawn H			#	0042424	Report Period	Beginning:	01/01/02	Ending:	12/31/02	_
V. COST CENTER EXPENSES (thro	ughout the report	, please round to	o the nearest d	ollar)							
		osts Per Genera			Reclass-	Reclassified	Adjust-	Adjusted	FOR OH	F USE ONLY	
Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total	_		
A. General Services	1	2	3	4	5	6	7**	8	9	10	
1 Dietary	261,662	16,488	6,567	284,717		284,717	(1,686)	283,031			1
2 Food Purchase		284,021		284,021		284,021	(75,745)	208,276			2
3 Housekeeping	147,474	28,876	4,178	180,528		180,528	(355)	180,173			3
4 Laundry	54,958	11,367	315	66,640		66,640		66,640			4
5 Heat and Other Utilities			118,630	118,630		118,630	(2,314)	116,316			5
6 Maintenance	48,546	6,724	121,713	176,983		176,983	(74,401)	102,582			6
7 Other (specify):*											7
8 TOTAL General Services	512,640	347,476	251,403	1,111,519		1,111,519	(154,501)	957,018			8
B. Health Care and Programs											
9 Medical Director			1,650	1,650		1,650		1,650			9
10 Nursing and Medical Records	1,617,685	122,740	244,085	1,984,510		1,984,510		1,984,510			10
10a Therapy		2,764	122,822	125,586		125,586		125,586			10a
11 Activities	96,159	7,764	6,982	110,905		110,905		110,905			11
12 Social Services	60,063	1,266	881	62,210		62,210		62,210			12
13 Nurse Aide Training			565	565		565		565			13
14 Program Transportation			382	382		382		382			14
15 Other (specify):*											15
16 TOTAL Health Care and Programs	1,773,907	134,534	377,367	2,285,808		2,285,808		2,285,808			16
C. General Administration											
17 Administrative	56,921		155,420	212,341		212,341	(155,420)	56,921			17
18 Directors Fees											18
19 Professional Services			21,653	21,653		21,653	2,543	24,196			19
20 Dues, Fees, Subscriptions & Promotions	S		48,963	48,963		48,963	1,513	50,476			20
21 Clerical & General Office Expenses	328,629	(1,013)	44,800	372,416		372,416	65,662	438,078			21
22 Employee Benefits & Payroll Taxes			466,581	466,581		466,581	89,144	555,725			22
23 Inservice Training & Education			3,639	3,639		3,639	(886)	2,753			23
24 Travel and Seminar			3,751	3,751		3,751	2,940	6,691		-	24
25 Other Admin. Staff Transportation			167	167		167	3,429	3,596			25
26 Insurance-Prop.Liab.Malpractice			96,417	96,417		96,417	6,149	102,566			26
27 Other (specify):*			· ·			<u> </u>		,		1	27
28 TOTAL General Administration	385,550	(1,013)	841,391	1,225,928		1,225,928	15,074	1,241,002			28

29

| 101AL Operating Expense | 2,672,097 | 480,997 | 1,470,161 | 4,623,255 | 4,623,255 | (139,427) |
| *Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. | SEE ACCOUNTANTS' COMPILATION NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification. | 4,623,255 | (139,427) | 4,483,828 | SEE ACCOUNTANTS' COMPILATION REPORT

TOTAL Operating Expense

^{**}See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

			Cost Per Genera	al Ledger		Reclass-	Reclassified	classified Adjust-		FOR OHF	USE ONLY	\Box
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			164,608	164,608		164,608	49,869	214,477			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,331	83,331		83,331	(8,184)	75,147			32
33	Real Estate Taxes			2,666	2,666		2,666	(2,666)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			250,605	250,605		250,605	39,019	289,624			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		10,228	1,179	11,407		11,407		11,407			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,728	48,728		48,728		48,728			42
43	Other (specify):* Nonallowable Costs			132,275	132,275		132,275	(132,275)				43
44	TOTAL Special Cost Centers		10,228	182,182	192,410		192,410	(132,275)	60,135			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,672,097	491,225	1,902,948	5,066,270		5,066,270	(232,683)	4,833,587			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

^{**} See schedule of adjustments attached at end of cost report.

4

Ending:

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	Til Column	1 2 below, reference the	1111e 011 WI	1 3	ai cosi
		1	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES	Amount	ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(75,745)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,865)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(355)	3		8
9	Non-Straightline Depreciation	(638)	30		9
10	Interest and Other Investment Income	(10,381)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,820)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,056)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax		<u> </u>	1	26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
	Other-Attach Schedule See Schedule 5A	(133,094)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (236,954)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	Z
		Amount	Reference
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
	Amortization of Organization &		
33	Pre-Operating Expense		33
	Adjustments for Related Organization		
34	Costs (Schedule VII)	4,271	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 4,271	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (232,683)	37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

	OHF USE ONL	V				
48		49	50	51	52	

Facility Name Maple Lawn Health Center

Provider # 0042424
Period Ending 12.31.02

Schedule 5A

VI. Adjustment Detail Line 29 - Other

Description	Amount	Schedule V Reference
Description	Amount	recicione
Vending Machine Offset	(1,686)	1
Real Estate Taxes	(5,227)	33
Flowers	(642)	43
Miscellaneous Income Offset	(869)	21
Management Fee (MLH)	(68,950)	43
Out of State Travel	(1,066)	24
Non-operating Expenses	(620)	43
Telephone	(6,588)	21
Non-allowable Dues	(304)	20
Laboratory	(994)	43
Radiology	(942)	43
Investment Market Adjustment	(43,525)	43
Professional Services	(651)	43
Miscellaneous Non-allowable expenses	(1,030)	43
Total	(133,094)	

See Accountants' Compilation Report

STATE OF ILLINOIS

Page 5A

Maple Lawn Health Center

	ID#	0042424	
Report Period Beginnin	ıg:	01/01/02	
Ending:		12/31/02	

Sch. V Line

	NON-ALLOWABLE EXPENSES	Amount	Reference	
1		s		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
	Total	0		49
	* **		1	

STATE OF ILLINOIS Summary A Ending: # 0042424 Report Period Beginning: 01/01/02 12/31/02

Facility Name & ID Number Maple Lawn Health Center

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61

	SUMMARY OF PAGES 5, 5A, 6, 6A	A, 6B, 6C, 6D,	6E, 6F, 6G, 61	1 AND 61										
													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	l
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	6I	(to Sch V, col	.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(75,745)	0	0	0	0	0	0	0	0	0	0	(75,745)	
3	Housekeeping	(355)	0	0	0	0	0	0	0	0	0	0	(355)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	(2,314)	0	0	0	0	0	0	0	0	0	(2,314)	
6	Maintenance	0	(74,401)	0	0	0	0	0	0	0	0	0	(74,401)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(76,100)	(76,715)	0	0	0	0	0	0	0	0	0	(152,815)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(155,420)	0	0	0	0	0	0	0	0	0	(155,420)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,820)	4,363	0	0	0	0	0	0	0	0	0	2,543	19
20	Fees, Subscriptions & Promotions	0	1,817	0	0	0	0	0	0	0	0	0	1,817	20
21	Clerical & General Office Expenses	0	73,119	0	0	0	0	0	0	0	0	0	73,119	21
22	Employee Benefits & Payroll Taxes	0	89,144	0	0	0	0	0	0	0	0	0	89,144	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,120	0	0	0	0	0	0	0	0	0	3,120	24
25	Other Admin. Staff Transportation	0	3,429	0	0	0	0	0	0	0	0	0	3,429	25
26	Insurance-Prop.Liab.Malpractice	0	6,149	0	0	0	0	0	0	0	0	0	6,149	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,820)	25,721	0	0	0	0	0	0	0	0	0	23,901	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(77,920)	(50,994)	0	0	0	0	0	0	0	0	0	(128,914)	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	6I	(to Sch V, col.	.7)
30	Depreciation	(638)	50,507	0	0	0	0	0	0	0	0	0	49,869	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,381)	2,197	0	0	0	0	0	0	0	0	0	(8,184)	32
33	Real Estate Taxes	0	2,561	0	0	0	0	0	0	0	0	0	2,561	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(11,019)	55,265	0	0	0	0	0	0	0	0	0	44,246	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(14,921)	0	0	0	0	0	0	0	0	0	0	(14,921)	43
44	TOTAL Special Cost Centers	(14,921)	0	0	0	0	0	0	0	0	0	0	(14,921)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(103,860)	4,271	0	0	0	0	0	0	0	0	0	(99,589)	45

0042424

Report Period Beginning:

01/01/02

Ending:

12/31/02

Page 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

11. Enter perent the manner of AE	_ 0 1111010 and 10	iated organizations (parties) as defined in the	io inioti dottorioi / titaori	an additional conce	iaio ii iioooccai ji		
1		2	3				
OWNERS		RELATED NURSING HOM	OTHER RELATED BUSINESS ENTITIES				
Name	Ownership %	Name	City	Name	City	Type of Business	
Maple Lawn Health Center, Inc.	100			Maple Lawn Homes	Eureka	Ret. House Mgmt	
				Maple Lawn Apart.	Eureka	Ret. Housing	
				Maple Lawn Cottage	Eureka	Ret. Housing	
				Maple Lawn			
				Living Care	Eureka	Home Care	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V	5	Utilities	\$ 8,400	Maple Lawn Homes	0.00%	\$ 6,086	\$ (2,314)	1
2	V	6	Maintenance Expense	78,934	Maple Lawn Homes	0.00%	4,533	(74,401)	2
3	V	17	Administrative Service Fees	155,420	Maple Lawn Homes	0.00%		(155,420)	3
4	V	19	Professional Services		Maple Lawn Homes	0.00%	4,363	4,363	4
5	V	20	Fees, Subscriptions & Prom.		Maple Lawn Homes	0.00%	1,817	1,817	5
6	V	21	Clerical & General Office		Maple Lawn Homes	0.00%	73,119	73,119	6
7	V	22	Employee Benefits		Maple Lawn Homes	0.00%	89,144	89,144	7
8	V	24	Travel Seminar		Maple Lawn Homes	0.00%	3,120	3,120	8
9	V	25	Other Admin. Staff Trans.		Maple Lawn Homes	0.00%	3,429	3,429	9
10	V	26	Insurance - Prop. Liab.		Maple Lawn Homes	0.00%	6,149	6,149	10
11	V	30	Depreciation		Maple Lawn Homes	0.00%	50,507	50,507	11
12	V	32	Interest		Maple Lawn Homes	0.00%	2,197	2,197	12
13	V	33	Real Estate Taxes		Maple Lawn Homes	0.00%	2,561	2,561	13
14	Total			\$ 242.754			s 247 025	\$ * 4.271	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name Maple Lawn Health Center

Provider # 0042424 Period Ending 12.31.02

Schedule 6A

VI. Related Parties

Board of Trustees

Don Oswald, Jr. James Sommer Chairman Secretary Tremont, IL Tremont, IL

James Thompson, Jr. Marjorie Schrader

Vice Chairman Treasurer Eureka, IL Metamora, IL

Deborah Byler William M. Sager

Washington, IL Eureka, IL

J. Barry Erdmier Claudene Schertz Morton, IL Metamora, IL

Velma Hirstein Wilmer Sears Morton, IL Tiskilwa, IL

Dorothy Harper Willis Sutter Roanoke, IL Eureka, IL

Mary Margaret Klaus

Eureka, IL

Note: No board member nor entity owned by board member provided services to the facility.

See Accountants' Compilation Report

Facility Name & ID Number

Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/02

Ending:

12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hou	ırs Per Work				
					Compensation		oted to this	Compensati	on Included	Schedule V.	
					Received		l % of Total	in Costs		Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10					_			•			10
11								•			11
12					_			•			12
13								TOTAL	\$		13

- * If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.
- ** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
 FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
 ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	Maple Lawn Homes
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	700 North Main
or parent organization costs? (See instructions.) YES X NO	City / State / Zip Code	Eureka, IL 61530
	Phone Number	((309) 467-2337
R Show the allocation of costs below. If necessary please attach worksheets	Fax Number	(309) 467-9097

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	5	Utilities	Accumulated Cost	6483794	8	\$ 9023	\$	4,373,522		1
2	6	Maintenance Expense	Time Study	17540	8	22987		3,459	4,533	2
3	19	Professional Services	Accumulated Cost	6483794	8	5993		4,373,522	4,042	3
4	19	Professional Services	Salary Allocation	782692	8	708		354,593	321	4
5	20	Fees, Subscriptions & Prom.	Accumulated Cost	6483794	8	2638		4,373,522	1,779	5
6	20	Fees, Subscriptions & Prom.	Salary Allocation	782692	8	84		354,593	38	6
7	21	Clerical, General Office Exp.	Accumulated Cost	6483794	8	108286		4,373,522	73,042	7
8	21	Clerical, General Office Exp.	Time Study	17540	8	388		3,459	77	8
9	22	Employee Benefits	Accumulated Cost	6483794	8	2951		4,373,522	1,991	9
10	22	Employee Benefits	Salary Allocation	782692	8	192373		354,593	87,153	10
11	24	Travel & Seminar	Accumulated Cost	6483794	8	4625		4,373,522	3,120	11
12	25	Other Admin. Staff Trans.	Accumulated Cost	6483794	8	5084		4,373,522	3,429	12
13	26	Insurance-Prop. Liab.	Accumulated Cost	6483794	8	9116		4,373,522	6,149	13
14		Depreciation	Accumulated Cost	6483794	8	74877		4,373,522	50,507	14
15	32	Interest	Accumulated Cost	6483794	8	3257		4,373,522	2,197	15
16	33	Real Estate	Accumulated Cost	6483794	8	3797		4,373,522	2,561	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 446,187	\$		\$ 247,025	25

			STATE OF	FILLINOIS			Page 9
Facility Name & ID Number	Maple Lawn Health Center	#	0042424	Report Period Beginning:	01/01/02	Ending:	12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	•	3	4	5	6	7	8	9	10	
											Reporting	
				_	Monthly	_			Maturity	Interest	Period]]
	Name of Lender	Relate		Purpose of Loan	Payment	Date of		nt of Note	Date	Rate	Interest]]
		YES	NO		Required	Note	Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related											
	Long-Term											
1	FHA Mortgage #1		X	Building	\$4,663.00	04/04/79	\$ 860,000		04/04/11	0.0500	\$ 19,064	1
2	FHA Mortgage #2		X	Building	\$6,300.00	07/07/89	900,000	612,781	07/07/14	0.0650	40,909	2
3	FHA Mortgage #3		X	Building	\$665.00	07/07/89	90,000	62,631	07/07/14	0.0713	4,578	3
4	City of Eureka Bonds		X	Building	\$3,465.00	07/07/89	455,000	304,744	07/07/12	0.0765	18,780	4
5	-											5
	Working Capital											
6	•											6
7												7
8												8
9	TOTAL Facility Related				\$15,093.00		\$ 2,305,000	\$ 1,340,152			\$ 83,331	9
	B. Non-Facility Related*			· ·	<u> </u>	4			•			
10	Interest Income Offset										(10,381)	10
11	Allocated from Management Co	mpany	•								2,197	11
12	3											12
13												13
												\Box
14	TOTAL Non-Facility Related						\$	\$			\$ (8,184)	14
15	TOTALS (line 9+line14)						\$ 2,305,000	\$ 1,340,152			\$ 75,147	15

¹⁶⁾ Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ n/a Line # n/a

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
0042424 Report Period Beginning: 01/01/02 Ending: 12/31/02

Facility Name & ID Number Maple Lawn Health Center

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
B. Real Estate Taxes

B. Real Estate Taxes							
		Important, please see the next worksheet, "RE	_Tax". The rea	estate tax statement and			+
1. Real Estate Tax accrual used	on 2001 report.	bill must accompany the cost report.			\$	2,600	1
2. Real Estate Taxes paid during	g the year: (Indicate the	tax year to which this payment applies. If payment covers r	nore than one year,	detail below.)	2001 \$	2,566	2
3. Under or (over) accrual (line	2 minus line 1).				\$	(34)	
4. Real Estate Tax accrual used	for 2002 report. (Detai	and explain your calculation of this accrual on the lines be	elow.)	Allocation from Management Co.	\$	2,561 2,700	
* * *		s NOT been included in professional fees or other general es of invoices to support the cost and a copy			s		5
classified as a real estate tax	cost plus one-half of any	6	otata tay anno	Nonexempt Real Estate Taxes		(5,227)	
7. Real Estate Tax expense repo	For orted on Schedule V, lin	Tax Year. (Attach a copy of the real e	state tax appea	i board's decision.)	s		7
Real Estate Tax History:							
Real Estate Tax Bill for Calen	dar Year: 1997	2,507 8		FOR OHF USE ONLY			T
	1998 1999	2,534 9 2,442 10	13	FROM R. E. TAX STATEMENT	FOR 2001	\$	13
	2000 2001	2,473 11 2,566 12	14	PLUS APPEAL COST FROM LI	NE 5	\$	14
2001 Real Estate Tax Bill	2,566	+W/L:1. 4L:4'4-: 501 (2)4 f5'4 ' '		LESS DEFLIND EDOM LINE S		e.	1
Est. Increase Est. 2002 Tax	2,700	*While this entity is a 501 (3) not-for-profit organization, it is paying real estate taxes for a portion of the	15	LESS REFUND FROM LINE 6		\$	15
Est. 2002 1 8X	facility that is deemed nonexempt. 16 AMOUNT TO USE FOR R					ION\$	16

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	Maple Lawn Hea			COUNTY	Woodford	i	
FAC	ILITY IDPH LICI	ENSE NUMBER	0042424					
CON	TACT PERSON	REGARDING TH	IS REPORTMr. Roger	Hasler				
TEL	EPHONE (309) 4	67-2337		FAX #: (3	09) 467-9	097		
A.		al Estate Tax Cos		_				
	cost that applies thome property w	to the operation of hich is vacant, ren	l estate tax assessed for the nursing home in Co ted to other organization de cost for any period of	dumn D. Rea ns, or used for	ıl estate ta r purpose:	x applicable s other than	to any por	tion of the nursir
	(A))	(B)			(C)		(D) <u>Tax</u> Applicable to
	Tax Index	Number	Property Descri	ption		Total Tax		Nursing Home
1.	13-12-201-026		Beauty Shop		\$	2,566.46	\$	None
2.					\$		\$	
3.					\$		\$	
4.							\$	
5.								
6.							\$	
7.					\$			
8.								
9.					\$		\$	
10.					\$			
				TOTALS	s	2,566.46	\$	None
B.	Real Estate Tax	Cost Allocations						
		of the tax bill app home services	ly to more than one nur YES	sing home, va		erty, or prop	erty which	is not direct
			chedule which shows th					ng hom

C. <u>Tax Bills</u>

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Page 10A

				STATE OF ILL				Page 11
	ity Name & ID Number Maple Law			# 0042	424 Report	Period Beginning:	01/01/02 Ending:	12/31/02
K. B	UILDING AND GENERAL INFOR	MATION:						
A.	Square Feet: 42,8	B. General Construction Type	e: Exterior	Brick	Frame	Brick, Motar, Steel	Number of Stories	2
C.	Does the Operating Entity?	X (a) Own the Facility	(b) Rent from	a Related Organ	zation.		(c) Rent from Completely Unr Organization.	elated
	(Facilities checking (a) or (b) must	t complete Schedule XI. Those checking	(c) may complete Schedu	ıle XI or Schedul	XII-A. See ins	tructions.		
D.	Does the Operating Entity?	X (a) Own the Equipment	(b) Rent equip	oment from a Rela	ited Organizati	on.	(c) Rent equipment from Com Unrelated Organization.	pletely
	(Facilities checking (a) or (b) must	complete Schedule XI-C. Those checki	ng (c) may complete Scho	edule XI-C or Sch	edule XII-B. Se	e instructions.		
E.	(such as, but not limited to, apartr List entity name, type of business, Maple Lawn Homes - Retirement Ho		ing facilities, day care, in	dependent living				
	Maple Lawn Apartments - Retiremen							
	Maple Lawn Cottages - Retirement H Maple Lawn Living Care - Home Car							
	Maple Lawn Living Care - Home Car	re						
F.	Does this cost report reflect any or If so, please complete the following	rganization or pre-operating costs whic g:	h are being amortized?			YES X	NO	
1.	. Total Amount Incurred:	N/A		2. Number of Y	ears Over Whic	h it is Being Amortized:	N/A	
3.	. Current Period Amortization:	N/A		4. Dates Incurre	d:	N/A		
		Nature of Costs: (Attach a complete schedule of	etailing the total amount	of organization a	nd pre-operatii	ig costs.)		
XI. C	OWNERSHIP COSTS:		•	•		4		
	A. Land.	Use	Square Feet	Year Acqu	rad	Cost		
	A. Danu.	1 Health Center	85,000		1965 \$	1,386 1	_	
		2 Health Center	39,000		1969	1,000 2	_	
		3 TOTALS	124,000		\$	2,386 3	-	
			= -,		_	<i>,</i>		

STATE OF ILLINOIS

Page 12 12/31/02 Facility Name & ID Number Maple Lawn Health Center # 0042

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar # 0042424 Report Period Beginning: 01/01/02 Ending:

	B. Buildi	ng Depreciation-Including Fixed Equ	ipment. (See inst	ructions.) Rour	id all numbers to nea	rest dollar					
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	80		1965	1965	\$ 472,000	\$ 7,867	60	\$ 7,867	S	\$ 298,278	4
5			1974	1974	20,378	408	50	408		11,570	5
6			1980	1980	750,017	16,667	45	16,667		381,614	6
7			1982	1982	7,703	385	20	385		7,772	7
8	38		1989	1989	1,459,363	32,430	45	32,430		437,807	8
	Impro	vement Type**	•								
9											9
10	LANDSCAPI	NG		1982	1,155	29	20	29		1,155	10
11	TREES			1984	1,125	56	20	56		1,050	11
12	TREES			1984	1,976	99	20	99		1,821	12
13	LANDSCAPI	NG		1992	1,100	64	10	64		1,100	13
14	ASPHALT RI	EPAIR		1993	4,058	406	10	406		3,686	14
15	PARKING LO	OT LIGHTING		1995	1,282	128	10	128		961	15
16	ASPHALT PA	ARKING LOT		1995	2,528	253	10	253		1,854	16
17	ADU ENCLO	SURE		1995	4,305	430	10	430		3,121	17
18	PARKING BI			1996	654	65	10	65		397	18
19	UPPER LOBI	BY RENOVATION - disposed of during y	/ear	1981		2,384	23	2,384			19
20	LOWER LEV	EL RENOVATION		1981	203,080	8,829	23	8,829		186,156	20
21		EL RENOVATION		1982	35,963	1,635	22	1,635		33,384	21
22		PAIRS & REFINISH		1983	9,750		10			9,750	22
23	TRELLIS			1983	1,063		10			1,063	23
24	LOADING DO			1985	1,642	82	20	82		1,443	24
25	ROOM RENO	OVATION - disposed of during year		1992		3	10	3			25
26	DECK			1992	2,574	193	10	193		2,574	26
27	ROOM RENO			1992	1,067	35	10	35		1,067	27
28	LOBBY REN			1993	32,583	3,258	10	3,258		31,496	28
29		UPPLY ROOM		1993	1,697	170	10	170		1,570	29
30	ADU CABINI			1994	1,365	114	10	114		996	30
31	WALLPAPEI			1994	776	57	12	57		776	31
32	WALLPAPEI	₹		1995	1,181	147	8	147		1,156	32
33							_				33
34		·									34
35											35
36											36

^{*}Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total SEE ACCOUNTANTS' COMPILATION REPORT

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Page 12A 12/31/02 Facility Name & ID Number Maple Lawn Health Center
XI. OWNERSHIP COSTS (continued) 0042424 Report Period Beginning: 01/01/02 Ending:

1	3	4	5	6	7	8	9	
	Year	. .	Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37 WALLPAPER	1995	\$ 194	\$ 24	8	\$ 24	\$	s 182	37
38 CARPET ROOM 702	1995	203	25	8	25		181	38
39 WALLCOVERING ADMIN OFFICE	1995	732	91	8	91		655	39
40 CONFERENCE ROOM WING 2	1995	512	64	8	64		448	40
41 DINING ROOM RENOVATION - disposed of during year	1996		588	8	588			41
42 LOBBY CARPET	1996	19,386	1,939	10	1,939		12,440	42
43 KITCHEN RAMP FLOORCOVERING	1996	526	66	8	66		418	43
44 BOILER REPAIRS - disposed of during year	1996		144	10	144			44
45 ROOM RENOVATING	1966	969	121	8	121		726	45
46 Walk in Freezer	1975	2,853		10			2,853	46
47 Sprinkler Installation	1976	11,240		20			11,240	47
48 Sprinkler Installation	1977	743		20			743	48
49 Generator	1980	9,500		20			9,500	49
50 Lite Fixture Lobby	1982	4,634	115	20	115		4,634	50
51 Floor Covering Ramps Renovation	1982	1,116		10			1,116	51
52 Kitchen Air Vent	1982	650	24	20	24		650	52
53 Floor Covering Lower Lobby - disposed of during year	1983			10				53
54 Exhaust Fan	1984	2,800	140	20	140		2,602	54
55 ENTRANCE LOAD CONTROL	1985	13,672		15			13,672	55
56 LIGHT FIXTURES	1985	936		10			936	56
57 WATER SOFTNER	1987	699		5			699	57
58 ALARM SYSTEM	1989	5,473	365	15	365		4,957	58
59 WANDER GUARD SYSTEM	1990	7,685		8			7,685	59
60 DOOR ALARMS	1990	1,461		8			1,461	60
61 GARBAGE DISPOSAL	1990	951		10			951	61
62 AIR CONDITIONING CONDENSER	1990	2,395	160	15	160		1,943	62
63 AIR CONDITIONING UNIT	1991	3,105	155	20	155		1,785	63
64 MANAGEMENT SYSTEM (5UNITS)	1991	1,163	77	15	77		884	64
65 PRIVACY CURTAINS	1991	11,200		10			11,200	65
66 WATER HEATER TANKS	1992	12,622	841	15	841		9,115	66
67 Century Whirlpool Tub	1993	3,284	219	15	219		2,135	67
68 LAUNDRY MACHINE MOTOR	1993	515	51	10	51		484	68
69 ASSEMBLY ROOM SOUND SYSTEM	1993	1,410	94	15	94		877	69
70 TOTAL (lines 4 thru 69)		\$ 3,143,014	\$ 81,497		\$ 81,497	\$	\$ 1,530,789	70

SEE ACCOUNTANTS' COMPILATION REPORT

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Page 12B 12/31/02 Facility Name & ID Number Maple Lawn Health Center # 00

XI. OWNERSHIP COSTS (continued)

R. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollars. # 0042424 Report Period Beginning: 01/01/02 Ending:

B. Building Depreciation-Including Fixed Equipment. (See ins	2	4	cst dollar	6	7	8		
1	Year	4	Current Book	6 Life	Straight Line	o	Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
	Constructed	\$ 3,143,014	\$ 81.497	III I Cars	\$ 81.497	e Aujustinents	\$ 1,530,789	1
1 Totals from Page 12A, Carried Forward 2 WANDER GUARD DOOR MONITOR	1993	1,212	3 01,497	0	3 01,497	3	1,330,789	
			1 200	8	1.055	(212)	,	2
3 MTC TELEPHONE SYSTEM	1993	10,769	1,289	10	1,077	(212)	9,871	3
4 PAGING SYSTEM	1994	707		3			707	4
5 ADU DOOR MONITORING SYSTEM - disposed of during year	1994			3				5
6 UPGRADE OF ELEVATOR	1994	3,298	330	10	330		2,804	6
7 AIR CONDITIONING-DINING ROOM	1994	1,723	86	20	86		717	7
8 HATCO TOASTER	1995	980	98	10	98		768	8
9 FIBER OPTICS WIRING	1995	4,645		5			4,645	9
10 DINING ROOM A/C UNIT	1995	3,187	159	20	159		1,221	10
11 WOOD GRAPHICS SIGNS	1995	1,131	67	7	67		1,131	11
12 KITCHEN SHELVES / COUNTER	1995	6,667	444	15	444		3,207	12
13 PARKER BATH	1995	8,598	860	10	860		6,091	13
14 MAGNETIC DOOR LOCK SYSTEM	1996	2,846	284	10	284		1,944	14
15 SERVICE SINK	1996	656	66	10	66		449	15
16 NURSE CALL SYSTEM	1996	21,777	2,178	10	2,178		13,248	16
17 A/C UNIT CENTRAL SUPPLY ROOM	1996	3,515	352	10	352		2,344	17
18 ELEVATOR UPGRADE	1996	13,117	1,312	10	1,312		8,745	18
19 A/C UNIT LAUNDRY ROOM	1996	5,986	599	10	599		3,991	19
20 A/C UNIT KITCHEN	1996	5,688	569	10	569		3,745	20
21 ALARM SYSTEM	1996	709	89	8	89		561	21
22 TEKTONE DOOR ALARM	1996	673	84	8	84		511	22
23 VERTICAL BLINDS	1994	1,021	117	8	117		1,021	23
24 LANDSCAPING	1997	3,116	312	10	312		1,766	24
25 REMODEL SMOKING AREA	1997	553	55	10	55		317	25
26 PATIENT ROOM RENOVATION	1997	979	122	8	122		694	26
27 LOBBY RENOVATION	1997	499	55	9	55		327	27
28 SINK & COUNTER FOR EMPLOYEE LOUNGE	1997	1,319	165	8	165		962	28
29 FIREPLACE CONVERSION	1997	2,762	276	10	276		1,564	29
30 KITCHEN WATERLINE REPLACEMENT	1997	1,591	159	10	159		821	30
31 CHAPEL RENOVATION	1997	17,045	1,704	10	1,704		8,522	31
32 NURSE CALL SYSTEM CORDS	1997	588	10	5	10		588	32
33 ADDRESSABLE FIRE ALARM SYSTEM	1997	11,790	1,179	10	1,179		6,976	33
34 TOTAL (lines 1 thru 33)		\$ 3,282,161	\$ 94,517		s 94,305	s (212)	s 1,622,259	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Page 12C 12/31/02 Facility Name & ID Number Maple Lawn Health Center # 00

XI. OWNERSHIP COSTS (continued)

R. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollars. # 0042424 Report Period Beginning: 01/01/02 Ending:

	B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar									
	1	3	4	5	6	7	8	, 9,,,		
	T (70 th	Year	C 4	Current Book	Life	Straight Line	4.12.4	Accumulated		
	Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	<u> </u>	
1	Totals from Page 12B, Carried Forward		\$ 3,282,161	\$ 94,517		\$ 94,305	\$ (212)	\$ 1,622,259	1	
	FIRE ALARM ANNUNCIATOR	1997	985	98	10	98		557	2	
3	EXPANSION TANK	1997	3,800	475	8	475		2,692	3	
4	DOOR SECURITY UPGRADE	1997	2,843	284	10	284		1,611	4	
5	PHONE SYSTEM ADDITIONS	1997	821	82	10	82		410	5	
6	BATHTUB	1997	6,080	608	10	608		3,040	6	
7	BATH LIFT	1997	3,294	329	10	329		1,645	7	
8	PARKING LOT REPAIR	1998	1,829	183	10	183		762	8	
9	LANDSCAPING	1998	700	70	10	70		309	9	
	BOILER REPAIRS	1998	2,415	241	10	241		1,188	10	
	AUTOMATIC DOOR	1998	3,651	365	10	365		1,704	11	
	WING 3 RENOVATION	1998	2,825	283	10	283		1,178	12	
13	DINING ROOM RENOVATION	1998	13,665	1,367	10	1,367		5,476	13	
	HALL 3 FIRE DETECTORS	1998	1,794	224	8	224		1,065	14	
	HALL 2 FIRE DETECTORS	1998	2,994	374	8	374		1,746	15	
	EMERGENCY GENERATOR REPAIRS	1998	1,356	136	10	136		622	16	
	FREE STANDING BATH	1998	8,958	896	10	896		3,882	17	
	SECURITY SYSTEM/AUD OUTDOOR GATE	1998	1,127	141	8	141		587	18	
	CABLE SYSTEM	1998	24,353	4,871	5	4,871		19,483	19	
	A/C LOWER LOBBY / BY DINING ROOM	1998	3,604	360	10	360		1,441	20	
21	ASPHALT REPAIR	1999	2,467	247	10	247		822	21	
22	DINING ROOM RENOVATION	1999	1,428	143	10	143		536	22	
	HALL 6 RENOVATION	1999	2,588	259	10	259		863	23	
	NEW DOOR FOR ENTRANCE	1999	2,665	267	10	267		844	24	
	HALL 7 RENOVATION	1999	6,647	665	10	665		2,050	25	
	BATH FLOORING	1999	2,018	252	8	252		778	26	
	JANITOR FLOOR	1999	326	41	8	41		126	27	
	HALL 1 RENOVATION	1999	2,276	285	8	285		878	28	
	ELECTRONIC EYE DOOR MAIN ENTRANCE	1999	3,723	372	10	372		1,116	29	
	OFFICE RENOVATION	1999	2,458	246	10	246		738	30	
-	LOUNGE RENOVATION	1999	927	93	10	93		279	31	
	DOOR ALARMS HALLS 1 & 3	1999	4,285	536	8	536		2,144	32	
	FIRE ALARMS HALLS 1, 6, 7	1999	5,290	661	8	661		2,479	33	
34	TOTAL (lines 1 thru 33)		\$ 3,406,353	\$ 109,971		s 109,759	\$ (212)	\$ 1,685,310	34	

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Page 12D 12/31/02 Facility Name & ID Number Maple Lawn Health Center # 0042

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar # 0042424 Report Period Beginning: 01/01/02 Ending:

l I	3	4	5	6	7	8	9	1
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12C, Carried Forward		s 3,406,353	\$ 109,971		s 109,759	\$ (212)	\$ 1,685,310	1
2 A/C CONDENSOR	1999	1,001	100	10	100		350	2
3 ADJUSTABLE SINK	1999	2,569	321	10	321		963	3
4 CAROUSEL WHIRLPOOL	1999	16,897	1,690	10	1,690		5,070	4
5 HEATING A/C UNIT HALL 6	1999	998	100	10	100		300	5
6 ASPHALT REPAIR	2000	2,352	235	10	235		529	6
7 TEMPERED WATER SYSTEM REDESIGNED	2000	14,400	720	20	720		1,920	7
8 RENOVATE SOCIAL SERVICE OFFICE	2000	3,422	342	10	342		884	8
9 WANDERGUARD MONITORS	2000	2,591	324	8	324		877	9
10 NEW BOILER IN CLEVELAND STEAMER	2000	4,076	408	10	408		918	10
11 OCTEL 100 VOICEMAIL SYSTEM	2000	6,260	1,253	5	1,253		2,820	11
12 CABLE SYSTEM EXPANSION	2000	1,844	369	5	369		768	12
13 Land Improvement - Sidewalk Replacement	2001	485	49	10	49		53	13
14 Water System Installation	2001	41,500	2,075	20	2,075		3,977	14
15 Administrative Office - Carpet	2001	1,447	181	8	181		317	15
16 FIRE ALARMS HALLS 4 &5	2001	6,436	804	8	804		1,608	16
17 Air Condition Unit Hall 6	2001	3,424	342	10	342		542	17
18 DOOR ALARMS HALLS 7	2001	2,757	344	8	344		430	18
19 Elevator Safety Edges	2002	3,245	189	10	189		189	19
20 Reshingle Roof - Memorial Hall	2002	739	12	20	12		12	20
21 A/C Condensor - HC lobby	2002	785	33	10	33		33	21
22 Cable System Upgrade	2002	1,138	76	5	76		76	22
23 Sandblasted Redwood Signs	2002	736	9	7	9		9	23
24								24
25								25
26								26 27
27								
28 29								28 29
			480			(480)		30
30 Non-Medicaid Assets			480			(480)		31
					14,425	14,425		32
32 Allocation From Management Company 33					14,425	14,425		33
34 TOTAL (lines 1 thru 33)		\$ 3,525,455	s 120,427		s 134,160	s 13,733	s 1,707,955	34
54 10 1712 (mics 1 mi u 55)		φ 3,343, 7 33	φ 120,72/		[J 137,100	g 13,733	9 1,707,933	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete

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		STATE OF ILLINOIS				Page 13
Facility Name & ID Number	Maple Lawn Health Center	# 0042424	Report Period Beginning:	01/01/02	Ending:	12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	c. Equipment Depreciation Excluding								
	Category of	1	•	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	1	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 370,358	\$	42,732	\$ 42,732	\$	Various	\$ 229,138	71
72	Current Year Purchases	29,133		1,503	1,503		Various	1,503	72
73	Fully Depreciated Assets	37,181						37,181	73
74	Allocation from Management Co	mpany			36,082	36,082			74
75	TOTALS	\$ 436,672	\$	44,235	\$ 80,317	\$ 36,082		\$ 267,822	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

	E. Summary of Care-Related Assets	1		2		
		Reference	A	mount		Ī
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	3,964,513	81]
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	164,662	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	214,477	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	49,815	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,975,777	85]

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Work in progress	\$ 226,245	92
93			93
94			94
95		\$ 226,245	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} This must agree with Schedule V line 30, column 8.

Faci	lity Name & I	D Number	Maple Lawn Health	Center		STATE OF ILLII # 0042424		Report Period	Beginning:	01/01/02	Ending:	Page 14 12/31/02
XII.	1. Name of 2. Does the	and Fixed Equ Party Holding	y real estate taxes in add		amount shown below o	on line 7, column 4?	NO					
		1 Year Constructe	2 Number ed of Beds	3 Date of Lease	4 Rental Amount	5 Total Yea of Lease						
3 4 5	Original Building: Additions	Construct	N/A	\$	Amount	of Ecus	Renewar	3 4 5		dates of curren		ment:
<u>6</u>	TOTAL			\$	**			6 7	11. Rent to b rental ag	e paid in future reement:	years under	the current
	This amo	unt was calcul ngth of the lea	ortization of lease expension that the dividing the total see N/A YES X	amount to be		N/A N/A	*		Fiscal Yea 12. 13. 14.	/2003 /2004 /2005	Annual Ross	ent
	B. Equipmen	nt-Excluding T ble equipment	Transportation and Fixed trental included in buildiovable equipment:	Equipment. (Sing rental?			X NO	he breakdown o	of movable equipm		<u> </u>	
	C. Vehicle R	ental (See inst	ructions.)			(12ttten it se	.cuure ucummig e		a movembre equipm	,		
	1 Use	,	2 Model Year and Make	M	3 Ionthly Lease Payment	4 Rental Exp for this Pe			* If there	is an option to	buy the build	ing.
17 18 19				\$ N	[/A	\$	17 18 19			provide complet		
20							20		** This an	nount plus any a	amortization o	of lease
21	TOTAL			\$		\$	21		expense	e must agree wit	h page 4, line	34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number	E W N A FDN I W I I W I I C		S	TATE OF ILLIN		24 B (B)		01/01/02	Б. И	Page 15
A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.) 1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? NO IN-HOUSE PROGRAM IN-HOUSE PROGRAM IN-HOUSE PROGRAM IN OTHER FACILITY IN OTHER FACILITY IN OTHER FACILITY A If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. B. EXPENSES ALLOCATION OF COSTS (d) C. CONTRACTUAL INCOME					# 00424	24 Report Perio	d Beginning:	01/01/02	Ending:	12/31/02
1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? NO IN-HOUSE PROGRAM IN OTHER FACILITY IN OTHER FACILITY IN OTHER FACILITY Of this schedule. If "no", provide an explanation as to why this training was not necessary. B. EXPENSES ALLOCATION OF COSTS (d) 3. CLINICAL PORTION: IN-HOUSE PROGRAM IN-HOUSE PROG	XIII. EXPENSES RELATING TO NURSE AIDE TRAINING I	PROGRAMS (See in	structions.)							
DURING THIS REPORT PERIOD? NO IN-HOUSE PROGRAM IN-HOUSE PROGRAM IN OTHER FACILITY IN OTHER FACILITY IN OTHER FACILITY OURS PER AIDE B. EXPENSES ALLOCATION OF COSTS (d)	A. TYPE OF TRAINING PROGRAM (If aides are trained	d in another facility	program, attach a s	chedule listing t	ne facility name, a	nddress and cost per a	aide trained in th	at facility.)		
IN OTHER FACILITY IN OTHER FACILITY IN OTHER FACILITY IN OTHER FACILITY X If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. B. EXPENSES ALLOCATION OF COSTS (d)		X YES 2.	CLASSROOM	PORTION:	<u> </u>	3.	CLINICAL POR	RTION:	_	
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. B. EXPENSES ALLOCATION OF COSTS (d) COMMUNITY COLLEGE X HOURS PER AIDE 40 B. CONTRACTUAL INCOME	PERIOD?	NO	IN-HOUSE PR	OGRAM			IN-HOUSE PRO	OGRAM		
of this schedule. If "no", provide an explanation as to why this training was not necessary. B. EXPENSES ALLOCATION OF COSTS (d) HOURS PER AIDE X HOURS PER AIDE 40 C. CONTRACTUAL INCOME	If "yes" please complete the remainder		IN OTHER FA	CILITY			IN OTHER FAC	CILITY	X	
B. EXPENSES ALLOCATION OF COSTS (d) HOURS PER AIDE 80 C. CONTRACTUAL INCOME			COMMUNITY	COLLEGE	X		HOURS PER AI	IDE	40	
B. EXPENSES C. CONTRACTUAL INCOME ALLOCATION OF COSTS (d)	explanation as to why this training was									
ALLOCATION OF COSTS (d)	not necessary.		HOURS PER A	IDE	<u>80</u>					
ALLOCATION OF COSTS (d)										
	B. EXPENSES	ALL OCATE	ON OF COORS	(B)		C. CON	TRACTUAL IN	COME		
In the box below record the amount of income your		ALLOCATI	ON OF COSTS	(d)				1.0		
			•	2	4					
1 2 3 4 facility received training aides from other facilities.		I		<u> </u>	4		facility received	training aide	s irom otno	er facilities.
Facility Drop-outs Completed Contract Total \$ N/A			,	Contract	T-4-1		6	NT/A	7	
Drop-outs Completed Contract Total S N/A 1 Community College Tuition S S 515 S S 515	1 Community College Tuition	Drop-outs		Contract		515	3	N/A		
2 Books and Supplies D, NUMBER OF AIDES TRAINED		3	\$ 313	J	Ф		IDED OF AIDES	TDAINED		
3 Classroom Wages (a)						D. NUN	IDER OF AIDES	IKAINED		
4 Clinical Wages (b) COMPLETED							COMPLETI	FD		
5 In-House Trainer Wages (c) 1. From this facility										
6 Transportation 2. From other facilities (f)								- 0		

50

565

565

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

7 Contractual Payments

9 TOTALS

8 Nurse Aide Competency Tests

10 SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

DROP-OUTS

2. From other facilities (f)

TOTAL TRAINED

1. From this facility

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Maple Lawn Health Center

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	, , ,	1	2	3	4	5	6	7	8	
		Schedule V	Staff		Outsid	e Practitioner	Supplies			Т
	Service	Line & Column	Units of	Cost	(other th	han consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C3	hrs	\$	653	\$ 33,531	\$	653 \$	33,531	1
	Licensed Speech and Language									
2	Development Therapist	L10a, C3	hrs		97	6,938		97	6,938	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C 2,3	hrs		1,109	57,423	2,764	1,109	60,187	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	L39, C2	prescrpts				10,228		10,228	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): IV Therapy	L39, C3				1,179			1,179	13
14	TOTAL			\$	1,859	\$ 99,071	\$ 12,992	1,859 \$	112,063	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Maple Lawn Health Center **Report Period Beginning:** 0042424 01/01/02 XV. BALANCE SHEET - Unrestricted Operating Fund.
This report must be completed even if financial statements are attached. As of 12/31/02 (last day of reporting year)

	1	Operating		2 After Consolidation*	
A. Current Assets					
Cash on Hand and in Banks	\$	201,661	\$	201,661	1
Cash-Patient Deposits					2
Accounts & Short-Term Notes Receivable-					
Patients (less allowance 29,881)		332,502		332,502	3
Supply Inventory (priced at Cost)		25,539		25,539	4
Short-Term Investments					5
Prepaid Insurance		283		283	6
Other Prepaid Expenses		6,412		6,412	7
Accounts Receivable (owners or related parties)					8
Other(specify): See Schedule 17A		94,692		94,692	9
TOTAL Current Assets					
(sum of lines 1 thru 9)	\$	661,089	\$	661,089	10
B. Long-Term Assets					
					11
		394,644		394,644	12
		2,386		2,386	13
8 /		3,546,576		3,525,455	14
Leasehold Improvements, at Historical Cost					15
Equipment, at Historical Cost		436,672		436,672	16
		(1,987,496)		(1,975,777)	17
					18
					19
					20
					21
(1 3)					22
Other(specify): Work-in-progress		226,245		226,245	23
TOTAL Long-Term Assets					
(sum of lines 11 thru 23)	\$	2,619,027	\$	2,609,625	24
TOTAL ACCETS					
	\$	3,280,116	\$	3,270,714	25
	Cash on Hand and in Banks Cash-Patient Deposits Accounts & Short-Term Notes Receivable- Patients (less allowance 29,881) Supply Inventory (priced at Cost) Short-Term Investments Prepaid Insurance Other Prepaid Expenses Accounts Receivable (owners or related parties) Other(specify): See Schedule 17A TOTAL Current Assets (sum of lines 1 thru 9) B. Long-Term Assets Long-Term Notes Receivable Long-Term Investments Land Buildings, at Historical Cost Leasehold Improvements, at Historical Cost Accumulated Depreciation (book methods) Deferred Charges Organization & Pre-Operating Costs Accumulated Amortization - Organization & Pre-Operating Costs Restricted Funds Other Long-Term Assets (specify): Other(specify): Work-in-progress TOTAL Long-Term Assets	A. Current Assets Cash on Hand and in Banks Cash-Patient Deposits Accounts & Short-Term Notes Receivable- Patients (less allowance 29,881) Supply Inventory (priced at Cost Short-Term Investments Prepaid Insurance Other Prepaid Expenses Accounts Receivable (owners or related parties) Other(specify): See Schedule 17A TOTAL Current Assets (sum of lines 1 thru 9) B. Long-Term Assets Long-Term Notes Receivable Long-Term Investments Land Buildings, at Historical Cost Leasehold Improvements, at Historical Cost Equipment, at Historical Cost Accumulated Depreciation (book methods) Deferred Charges Organization & Pre-Operating Costs Accumulated Amortization - Organization & Pre-Operating Costs Restricted Funds Other Long-Term Assets (specify): Other(specify): Work-in-progress TOTAL Long-Term Assets (sum of lines 11 thru 23) \$	A. Current Assets Cash on Hand and in Banks Cash-Patient Deposits Accounts & Short-Term Notes Receivable-Patients (less allowance 29,881) 332,502 Supply Inventory (priced at Cost) 25,539 Short-Term Investments Prepaid Insurance 283 Other Prepaid Expenses 6,412 Accounts Receivable (owners or related parties) Other(specify): See Schedule 17A 94,692 TOTAL Current Assets (sum of lines 1 thru 9) \$ 661,089 B. Long-Term Notes Receivable Long-Term Notes Receivable Long-Term Investments 394,644 Land 2,386 Buildings, at Historical Cost 3,546,576 Leasehold Improvements, at Historical Cost 436,672 Accumulated Depreciation (book methods) Deferred Charges Organization & Pre-Operating Costs Accumulated Amortization - Organization & Pre-Operating Costs Restricted Funds Other Long-Term Assets (specify): Other(specify): Work-in-progress 226,245 TOTAL Long-Term Assets (sum of lines 11 thru 23) \$ 2,619,027	A. Current Assets Cash on Hand and in Banks Cash-Patient Deposits Accounts & Short-Term Notes Receivable- Patients (less allowance 29,881) Supply Inventory (priced at Cost) 25,539 Short-Term Investments Prepaid Insurance 283 Other Prepaid Expenses 6,412 Accounts Receivable (owners or related parties) Other(specify): See Schedule 17A 94,692 TOTAL Current Assets (sum of lines 1 thru 9) \$ 661,089 \$ B. Long-Term Assets Long-Term Notes Receivable Long-Term Investments 394,644 Land 2,386 Buildings, at Historical Cost 3,546,576 Leasehold Improvements, at Historical Cost Equipment, at Historical Cost 436,672 Accumulated Depreciation (book methods) Deferred Charges Organization & Pre-Operating Costs Restricted Funds Other Long-Term Assets (specify): Other(specify): Work-in-progress TOTAL Long-Term Assets (sum of lines 11 thru 23) \$ 2,619,027 \$	Operating

		1	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	68,192	\$ 68,192	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits				28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		192,055	192,055	30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		12,943	12,943	31
32	Accrued Real Estate Taxes(Sch.IX-B)		2,700	2,700	32
33	Accrued Interest Payable		6,360	6,360	33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	See Schedule 17A		32,479	32,479	36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	314,729	\$ 314,729	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable		1,340,152	1,340,152	39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43				_	43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	1,340,152	\$ 1,340,152	45
	TOTAL LIABILITIES	Ì			
46	(sum of lines 38 and 45)	\$	1,654,881	\$ 1,654,881	46
	,		, ,		
47	TOTAL EQUITY(page 18, line 24)	\$	1,625,235	\$ 1,615,833	47
	TOTAL LIABILITIES AND EQUITY	Ÿ			
48	(sum of lines 46 and 47)	\$	3,280,116	\$ 3,270,714	48

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SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name Maple Lawn Health Center

Provider # 0042424 Period Ending 12.31.02

Schedule 17A

XV. Balance Sheet

A. Current Assets - Line 9: Other (specify):

Interest Receivable	1,408
Service Division	88,740
Apartments	265
Forwarding Acts Intercom	4,741
Transportation	(462)

Total 94,692

A. Current Liabilites - Line 36: Other Current Liabilities (specify):

Uniform Deduction	(120)
Section 125 Dental Insurance	748
Wage Garnishment Deduction	203
Pharmacy Withholding	(77)
Loan Term Care Insurance	222
Section 125 Colonial Insurance	139
Section 125 - Travelers Canter Insurance	23
Annuity 403(b) plan	31,341
Total	32,479

See Accountants' Compilation Report

XVI. STATEMENT	OF (CHANGES	IN EQUITY

JF CI	IANGES IN EQUITY				
			1		1
			Total		
1	Balance at Beginning of Year, as Previously Reported	\$	1,642,660	1	
2	Restatements (describe):			2	
3				3	
4				4	
5				5	
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	1,642,660	6	
	A. Additions (deductions):				
7	NET Income (Loss) (from page 19, line 43)		(17,425)	7	
8	Aquisitions of Pooled Companies			8	
9	Proceeds from Sale of Stock			9	
10	Stock Options Exercised			10	
11	Contributions and Grants			11	
12	Expenditures for Specific Purposes			12	
13	Dividends Paid or Other Distributions to Owners	()	13	
14	Donated Property, Plant, and Equipment			14	
15	Other (describe)			15	
16	Other (describe)			16	Ì
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	(17,425)	17	Ī
	B. Transfers (Itemize):				
18				18	
19				19	
20				20	
21				21	1
22				22	1
23	TOTAL Transfers (sum of lines 18-22)	\$		23	1
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	1,625,235	24	*
	. , , , , , , , , , , , , , , , , , , ,			•	

Operating Entity Only

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 5,367,125	1
2	Discounts and Allowances for all Levels	(922,752)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,444,373	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	250,739	6
7	Oxygen	13,447	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 264,186	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,373	13
14	Non-Patient Meals	75,745	14
15	Telephone, Television and Radio	12,530	15
16	Rental of Facility Space		16
17	Sale of Drugs	10,228	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,911	19
20	Radiology and X-Ray	127	20
21	Other Medical Services	94,477	21
22	Laundry	355	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 205,746	23
	D. Non-Operating Revenue		
	Contributions	130,725	24
	Interest and Other Investment Income***	10,381	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 141,106	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	(6,566)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (6,566)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,048,845	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,111,519	31
32	Health Care	2,285,808	32
33	General Administration	1,225,928	33
	B. Capital Expense		
34	Ownership	250,605	34
	C. Ancillary Expense		
35	Special Cost Centers	143,682	35
36	Provider Participation Fee	48,728	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,066,270	40
44	Y 1 6 Y T (!! 20 ! !! 40\th	(15.425)	44
41	Income before Income Taxes (line 30 minus line 40)**	(17,425)	41
42	Income Taxes		42
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (17,425)	43

This must agree with page 4, line 45, column 4.

Does this agree with taxable income (loss) per Federal Income No If not, please attach a reconciliation. Tax Return? This entity is a division of a not-for-profit organization.

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a SEE ACCOUNTANTS' COMPILATION REPORT detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name Maple Lawn Health Center

Provider # 0042424 Period Ending 12.31.02

Schedule 19A

XVII. Income Statement E. Other Revenue

Description	Am	ount
Equipment Rental - PP	\$	453
Equipment Rental - IPA		365
Vending Machine		1,686
Admission Fee		6,000
Loss on Sale of Fixed Asset		(15,939)
Miscellaneous		869
Total	\$	(6,566)

See Accountants' Compilation Report

Facility Name & ID Number Maple Lawn Health Center

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	(This schedule must cover the	entire reporting					В. С	CONSULTANT SERVICES	
		1	2**	3	4				
		# of Hrs.	# of Hrs.	Reporting Period	Average				Ni
		Actually	Paid and	Total Salaries,	Hourly				0
		Worked	Accrued	Wages	Wage				P
1	Director of Nursing	1,739	1,846	\$ 45,020	\$ 24.39	1			Ac
	Assistant Director of Nursing	1,789	2,080	42,637	20.50		35	Dietary Consultant	
3	Registered Nurses	13,779	14,504	294,009	20.27	3	36	Medical Director	Mor
4	Licensed Practical Nurses	13,273	14,427	241,359	16.73	4	37	Medical Records Consultant	Mor
5	Nurse Aides & Orderlies	74,688	80,656	913,855	11.33	5	38	Nurse Consultant	
6	Nurse Aide Trainees					6	39	Pharmacist Consultant	Mor
7	Licensed Therapist					7	40	Physical Therapy Consultant	
8	Rehab/Therapy Aides	3,977	4,621	53,519	11.58	8	41	Occupational Therapy Consultant	
9	Activity Director	1,838	2,092	26,990	12.90		42	Respiratory Therapy Consultant	
10	Activity Assistants	4,243	4,698	39,956	8.50		43	Speech Therapy Consultant	
11	Social Service Workers	5,148	5,642	60,063	10.65		44	Activity Consultant	
12	Dietician					12	45	Social Service Consultant	
13	Food Service Supervisor	3,455	4,009	48,105	12.00	13	46	Other(specify)	
14	Head Cook	6,970	7,699	74,687	9.70	14	47		
15	Cook Helpers/Assistants	15,638	16,998	138,870	8.17	15	48		
16	Dishwashers					16			
17	Maintenance Workers	3,616	4,045	48,546	12.00	17	49	TOTAL (lines 35 - 48)	
18	Housekeepers	16,366	17,985	147,474	8.20		l	<u> </u>	•
19	Laundry	6,424	6,963	54,958	7.89	19			
20	Administrator	1,705	2,059	56,921	27.64	20			
21	Assistant Administrator					21	C. C	CONTRACT NURSES	
22	Other Administrative					22			
23	Office Manager					23			Nı
24	Clerical	4,876	5,300	51,795	9.77	24			0
25	Vocational Instruction					25			P
26	Academic Instruction					26			Ac
27	Medical Director					27	50	Registered Nurses	
28	Qualified MR Prof. (QMRP)					28	51	Licensed Practical Nurses	
29	Resident Services Coordinator					29	52	Nurse Aides	
30	Habilitation Aides (DD Homes)					30			
31	Medical Records				İ	31	53	TOTAL (lines 50 - 52)	
32	Other Health Ca See Schedule 20A	3,467	3,785	56,499	14.93	32			
33	Other(specify) See Schedule 20A	13,461	15,011	276,834	18.44	33			
34	TOTAL (lines 1 - 33)	196,452	214,420	\$ 2,672,097 *	s 12.46	34	SEE ACC	COUNTANTS' COMPILATION RE	PORT

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	207	s 4,786	L1, C3	35
36	Medical Director	Monthly	1,650	L9, C3	36
37	Medical Records Consultant	Monthly	260	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	L10, C3	39
40	Physical Therapy Consultant	262	12,534	L10a, C3	40
41	Occupational Therapy Consultant	262	12,396	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	648	L11, C3	44
45	Social Service Consultant	14	700	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	760	\$ 34,774		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses	365	\$ 19,332	L10, C3	50
51	Licensed Practical Nurses	1,885	61,327	L10, C3	51
52	Nurse Aides	8,759	154,101	L10, C3	52
53	TOTAL (lines 50 - 52)	11,009	\$ 234,760		53

^{*} This total must agree with page 4, column 1, line 45.

^{**} See instructions.

Facility Name Maple Lawn Health Center Provider # 0042424
Period Ending 12.31.02

Schedule 20A

XVIII. Staffing and Salary Costs

	Hours Worked	Hours Paid	Salary	Avg Hr Wage	Cost Report Line
Nurse Secretary	1,724	1,994	23,653	11.86	10
Ward Clerk	329	377	3,633	9.64	10
Chaplain	1,414	1,414	29,213	20.66	11
Total Line 32 - Other Health Care	3,467	3,785	56,499	14.93	
Human Resources	2,379	2,465	44,066	17.88	21
Accounting & Other Admin	9,684	10,914	207,561	19.02	21
Volunteer Coordinator	1,398	1,632	25,207	15.45	21
Total Line 33 - Other	13,461	15,011	276,834	18.44	

See Accountants' Compilation Report

STATE OF ILLINOIS			Page	e 21
11 00 10 10 1	D (D 1 1D 1 1	04/04/03	г	10/01

				STA	TE OF ILLINOIS				Pag	e 21
	aple Lawn Health Center			#_004	2424	Report Period Beg	inning: 01/0	01/02 E	inding:	12/31/02
XIX. SUPPORT SCHEDULES										
A. Administrative Salaries	Owne			D. Employee Benefits and				Subscriptions and Pr	omotions	
Name	Function %	0	Amount		ription	Amount		cription		Amount
Steve Evans	Administrator	<u> </u>	56,921	Workers' Compensation In		\$ 50,853	IDPH License I			27
				Unemployment Compensa	tion Insurance			nployee Recruitmen		28,85
				FICA Taxes		172,060		orker Background C		
				Employee Health Insurance	ee	168,015			<u>104</u>)	1,2
				Employee Meals			Miscellaneous S			19
				Illinois Municipal Retirem	ent Fund (IMRF)*		Mennonite Hea	lth Services		10,92
				Employee Physical		1,075	Life Services N	etwork		5,0
TOTAL (agree to Schedule V, line 1	7, col. 1)			Annuity Plan 403B		42,486	Miscellaneous l	Dues		2,07
(List each licensed administrator se	parately.)	\$	56,921	Sick Pay		8,585				
B. Administrative - Other				Group Life Insurance		4,474	Allocation from	Management Com	oany	1,8
				Employee Appreciation		6,880	Less: Public R	telations Expense	(
Description			Amount	Allocation from Managem	ent Company	89,144	Non-allo	wable advertising		
Phone Fee (MLH) (Eliminated in Co	olumn 7)	\$	600	Other Employee Benefits	•	12,153	Yellow p	age advertising		
Administrative Fee (MLH) (Elimina	ited in Column 7)		80,683				•		`	
Chaplain Fee (MLH) (Eliminated in	Column 7)		25,839	TOTAL (agree to Schedul	le V.	\$ 555,725	ТО	TAL (agree to Sch. V	V. \$	50,4
Human Resources (MLH) (Eliminat			48,298	line 22, col.8)	,			line 20, col. 8)	· •	
TOTAL (agree to Schedule V, line 1			155,420	E. Schedule of Non-Cash (Compensation Paid		G. Schedule of	Travel and Seminar	k*	
Attach a copy of any management			,	to Owners or Employee						
C. Professional Services	service agreement)			to owners or Employee	3		Des	cription		Amoun
Vendor/Pavee	Туре		Amount	Description	Line#	Amount		cription		rimoun
Heinold-Banwart Ltd.	Accounting	•	8,400	Description	Line #	\$ Amount	Out-of-State Ti	esval	•	
American Express Tax	Accounting		0,400	N/A			Out-or-State 11	avei		
and Business Services	Accounting		8,500	IVA						
Leiken & Lankton, LLC	Legal		38			· —	In-State Travel			7.
Life Services Network	Consulting		977			· —	in-State Travel			
Line Services Network Lincoln National	Section 125 Adminstrati	 .	70			· <u> </u>				
						<u> </u>				
Small, Parker & Blossom, Inc.	Section 125 Adminstrati		203				C E			• • •
Alliance Benefit Group	Section 125 Adminstrati	ion	1,645				Seminar Expen	se		2,8
Centers for Medicaid & Medicare	Civil Penalty		1,820			· ——				
							Allocation from	Management Co.		3,1
							Entertainment		(
TOTAL (agree to Schedule V, line 1			21,653	TOTAL		\$		(agree to Sch. V,		
(If total legal fees exceed \$2500 attack							TOTAL	line 24, col. 8)	\$	6,69

* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name Maple Lawn Health Center

Provider # 0042424 Period Ending 12.31.02

Schedule 21A

XIX. Support Schedule

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	21,653
Allocation From Management Company	4,363
Non-allowable Civil Penalty	(1,820)

Total (agree to Schedule V, line 19, column 8) 24,196

See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3 N	V/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													1
20	TOTALS		s		s	\$	\$	\$	s	\$	s	s	s

	:	STATE O	F ILLINOIS				Page 23
	y Name & ID Number Maple Lawn Health Center	#	0042424	Report Period Beginning:	01/01/02	Ending:	12/31/02
	ENERAL INFORMATION:						
(1)	Are nursing employees (RN,LPN,NA) represented by a union? No	` '	the Department of	supplies and services which are of the Public Aid, in addition to the daily ra			
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Life Services Network - \$5,083		•	ction of Schedule V? Yes	_		c
(3)	Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A		the patient census is a portion of the	building used for any function other thisted on page 2, Section B? No building used for rental, a pharmacy, explains how all related costs were all	day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A	. ,	Indicate the cost of on Schedule V. related costs?		ssified to empl meal income l the amount.	been offset ag	
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? Yes 10		Travel and Transp	ortation ncluded for out-of-state travel?	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 58,539 Line 10		If YES, attach a	complete explanation. eparate contract with the Department	to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.		program during c. What percent of	this reporting period. \$ N/A all travel expense relates to transportage logs been maintained? Adequa	tation of nurse	s and patients	10
(8)	Are you presently operating under a sale and leaseback arrangement: No No N/A		e. Are all vehicles times when not	stored at the nursing home during the in use? N/A	night and all	othei	•
(9)	Are you presently operating under a sublease agreement? YES X NO)	out of the cost re	commuting or other personal use of a country N/A sty transport residents to and from	-		N/A
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over	Ι,	Indicate the a transportation	mount of income earned from p n during this reporting period.	roviding suc	h	
	N/A		Firm Name: He	performed by an independent certifie einold-Banwart, Ltd.		The instruct	tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 48,728 This amount is to be recorded on line 42 of Schedule V.		been attached?		N/A		
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.		out of Schedule V			-	
	SEE ACCOUNTANTS' COMPILATION REPORT		performed been att	re in excess of \$2500, have legal involuted to this cost report? N/A d a summary of services for all archives.		-	ices

RECONCILIATION REPORT Maple Lawn Her	ealth Cent 03:31 PM	11/04/05
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RECONCILIATION REPORT	Maple Lawn	Health Cen	03:31 PM	11/04/05										
						Emboration		SUB-	LINE	COL.	i	SUB-	LINE	COL.
ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	Explanation	COMPARE CEL	SCHED.	NO.	NO.	WITH CELL	SCHED.	NO.	NO.
Adjustment Detail	-232.683	equal to	-232.683	0	O.K.		Pg5 Z22	В.	37	1	Pg4 K29	N/A	45	7
Interest Expense	75,147	equal to	75,147	0	O.K.		Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.		Pg10 W24	В.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!		Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	214,477	equal to	214,477	0	O.K.		Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.		Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.		Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	565	equal to	565	0	O.K.		Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv Staff Wages		equal to		0	O.K.		Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	125,586	equal to	125,586	0	O.K.		Pg16 Z12+Z14	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv Supplies	12,992	equal to	12,992	0	O.K.	Per Bob, it agrees to pg.4 L39	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,111,519	equal to	1,111,519	0	O.K.		Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,285,808	equal to	2,285,808	0	O.K.		Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,225,928	equal to	1,225,928	0	O.K.		Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	250,605	equal to	250,605	0	O.K.		Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	143,682	equal to	143,682	0	O.K.		Pg19 P17	N/A	35	2	Pg4 H21H24+F	N/A	38to41+43	4
Income Stat. Prov. Partic.	48,728	equal to	48,728	0	O.K.	and the state of t	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,536,880	equal to	1,617,685	-80,805	FAILED	unit clerk, nursing sec & rehab aid salaries.	Pg20 K11K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.		Pg20 K16	Α.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	charlin ach204	Pg20 K17	Α.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	66,946	equal to	96,159	-29,213	FAILED	chaplin-sch20A	Pg20 K19+K20	Α.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	60,063	equal to	60,063	0	O.K.		Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	261,662	equal to	261,662	0	O.K.		Pg20 K22K26	Α.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	48,546	equal to	48,546	0	O.K.		Pg20 K27	Α.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	147,474	equal to	147,474	0	O.K.		Pg20 K28	Α.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	54,958	equal to	54,958	0	O.K.		Pg20 K29	Α.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	56,921	equal to	56,921	0	O.K.	clerical-sch20A	Pg20 K30K32	Α.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	51,795	equal to	328,629	-276,834	FAILED	CIETICAI-SCH2UA	Pg20 K33K34	Α.	23+24	3	Pg3 E32	N/A	21 9	1
Staff- Medical Director	0	equal to		0	O.K.		Pg20 K37	Α.	27	3	Pg3 E18	N/A	-	1
Total Salaries And Wages	2,672,097	equal to	2,672,097	0	O.K.	minor equipment	Pg20 K44	A. B	34 35	2	Pg4 E29	N/A N/A	45 1	3
Dietary Consultant Medical Director	4,786 1.650	< or = to < or = to	6,567 1.650	-1,781 0	O.K.	minor equipment	Pg20 X12 Pg20 X13	В.	36	2	Pg3 G9 Pg3 G18	N/A N/A	9	3
Consultants & contractors	236,820	< or = to	244,085	-7,265	O.K.	minor equipment & use appreciation	Pg20 X13 Pg20 X14X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	648		6,982	-6,334	O.K.	equipment & other in supplies	Pg20 X14X107	В. а.С.	371039 and 30103	2	Pg3 G21	N/A	11	3
Social Service Consultant	700	< or = to < or = to	881	-0,334	O.K.	minor equipment	Pg20 X21 Pg20 X22	В.	44	2	Pg3 G21 Pg3 G22	N/A N/A	12	3
Supp. Sched Admin. Salar.	56,921	equal to	56,921	-101	O.K.	minor equipment	Pg21 I16	Δ.	N/A	N/A	Pg3 G22 Pg3 E28	N/A	17	1
Supp. Sched Admin. Other	155,420	equal to	155,420	0	O.K.		Pg21 I24	В.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched Prof. Serv.	21,653	equal to	21.653	0	0.K.		Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched Benefit/Taxes	555,725	equal to	555,725	0	O.K.		Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched Sched of dues	50,476	equal to	50.476	0	0.K.		Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched Sched of trav	6,691	equal to	6,691	0	O.K.		Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	48,728	equal to	48,728	0	O.K.		Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	89,144	-89,144	O.K.	employee benefits allocation	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.		Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.		Pg15 U29U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	827	equal to	827	0	O.K.		Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	4,271	equal to	4,271	0	O.K.		Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y40	B.	14	8
Total loan balance	1,340,152	equal to	1,340,152	0	O.K.		Pg9 L34	A.	15	7	Pg17 V13+V27	N/A	29+39-41	2
Real estate tax accrual	2,700	equal to	2,700	0	O.K.		Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	2,386	equal to	2,386	0	O.K.		Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,525,455	equal to	3,525,455	0	O.K.		Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	436,672	equal to	436,672	0	O.K.		Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,975,777	equal to	1,975,777	0	O.K.		Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,625,235	equal to	1,625,235	0	O.K.		Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-17,425	equal to	-17,425	0	O.K.		Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.		Pg22 F31-J31S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,280,116	equal to	3,280,116	0	O.K.		Pg17:H41		25	1	Pg17 S41	N/A	48	1

		Reclass-	Reclassifie	d	Adjusted
Salaries Supplies Other	Total			- Adjustmen	•
1. Dietary 261,662 16,488 6,56				-1,686	
	284,021		,	-75,745	,
3. Housek 147,474 28,876 4,17	,		,	-355	,
4. Laundry 54,958 11,367 31	,		,	0	66,640
5. Heat ar 0 0 118,63				-2,314	
6. Mainter 48,546 6,724 121,71	,		,	,	,
) (0	0	0
•	3 1,111,519		1,111,519		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ,-		, ,-	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
9. Medica 0 0 1,65	1,650	0	1,650	0	1,650
10. Nursin 1,617,685 122,740 244,08	5 1,984,510	0	1,984,510	0	1,984,510
10a. Thera 0 2,764 122,82	2 125,586	0	125,586	0	125,586
11. Activit 96,159 7,764 6,98	2 110,905	5 0	110,905	0	110,905
12. Social 60,063 1,266 88				0	62,210
13. Nurse 0 0 56	,		- , -	0	565
14. Progra 0 0 38.				0	382
) 0			0	0
	7 2,285,808		2,285,808		2,285,808
,	_,,_,		_,,		_,,_,
17. Admin 56,921 0 155,42	212,341	0	212,341	-155,420	56,921
18. Direct: 0 0	0 0	0	0	0	0
19. Profes 0 0 21,65	3 21,653	0	21,653	2,543	24,196
20. Fees, 0 0 48,96	3 48,963	0	48,963	1,513	50,476
21. Cleric: 328,629 -1,013 44,80	372,416	0	372,416	65,662	438,078
22. Emplo 0 0 466,58	1 466,581	0	466,581	89,144	555,725
23. Inserv 0 0 3,63				-886	2,753
24. Travel 0 0 3,75				2.940	6,691
25. Other 0 0 16			,	3,429	3,596
26. Insura 0 0 96,41	7 96.417	0	96.417	6,149	
) (,	0	0
	1 1,225,928		1,225,928		1,241,002
, , , , , , , , , , , , , , , , , , , ,	, -,-		, -,-	-,-	, ,
29. Total (2,672,097 480,997 1,470,16	1 4,623,255	5 0	4,623,255	-139,427	4,483,828
30. Depre 0 0 164,60	3 164,608	3 0	164,608	49,869	214,477
·) 104,000		,	49,009	0
32. Intere: 0 0 83,33				-8,184	75.147
33. Real E 0 0 2,66	,		,	-2,666	73,147
, , ,) 2,000		,	-2,000	0
- 11 11 11 11 11 11 11 11 11 11 11 11 11				0	0
	0 00			0	0
37. Total (0 0 250,60	5 250,605	5 0	250,605	39,019	289,624
38. Medic: 0 0	0	0	0	0	0
39. Ancilla 0 10,228 1,179	9 11,407	0	11,407	0	11,407
40. Barbel 0 0) (0	0	0	0
) (0	0
42 0 0 48,72				0	48,728
43. Other 0 0 132,27	,		-, -	-132,275	0
44. Total (0 10,228 182,18.			,	-132,275	60,135
45. Grand 2,672,097 491,225 1,902,94			5,066,270	,	4,833,587
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	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	201,661	201,661
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	332,502	332,502
4. Supply Inventory	25,539	
5. Short-Term Investments	0	0
6. Prepaid Insurance	283	
7. Other Prepaid Expenses	6,412	6,412
Accounts Receivable-Owner/Related Party	0	,
9. Other (specify):	94,692	
10. Total current assets	661,089	,
LONG TERM ASSETS	001,000	001,000
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	394,644	
13. Land	2,386	,
	2,360 3,546,576	
14. Buildings, at Historical Cost		
15. Leasehold Improvements, Historical Cost	426.672	-
16. Equipment, at Historical Cost	436,672	,
17. Accumulated Depreciation (book methods)	-1,987,496	
18. Deferred Charges	0	
19. Organization & Pre-Operating Costs	0	
20. Accum Amort - Org/Pre-Op Costs	0	
21. Restricted Funds	0	
22. Other Long-Term Assets (specify):	0	-
23. other (specify):	226,245	,
24. Total Long-Term Assets	2,619,027	
25. Total Assets	3,280,116	3,270,714
CURRENT LIABILITIES		
26. Accounts Payable	68,192	
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	-
29. Short-Term Notes Payable	0	
30. Accrued Salaries Payable	192,055	192,055
31. Accrued Taxes Payable	12,943	12,943
32. Accrued Real Estate Taxes	2,700	
33. Accrued Interest Payable	6,360	6,360
 Deferred Compensation 	0	0
Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	32,479	32,479
Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	314,729	314,729
LONG TERM LIABILITES		
39.Long-Term Notes Payable	1,340,152	1,340,152
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,340,152	1,340,152
46.Total Liabilities	1,654,881	
47.Total Equity	1,625,235	
48.Total Liabilities and Equity	3,280,116	
	-,,	-,,-

Gross Revenue - All levels of Care Discounts and Allowances for all Levels	Balance per Medicaid Trial Balance 5,367,125 -922,752
Subtotal - Inpatient Care	4,444,373
4. Day Care	0
Other Care for Outpatients	0
6. Therapy	250,739
7. Oxygen	13,447
Subtotal - Anciliary Revenue	264,186
Payments for Education	0
Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	4,373
14. Non-Patient Meals	75,745
15. Telephone, Television, and Radio16. Rental of Facility Space	12,530 0
17. Sale of Drugs	10,228
18. Sale of Supplies to Non-Patients	0
19. Laboratory	7,911
20. Radiologyand X-Ray	127
21. Other Medical Services	94,477
22. Laundry	355
Subtotal - Other Operating Revenue	205,746
24. Contributions	130,725
25. Interest and Other Investments Income	10,381
Subtotal - Non-Operating Revenue	141,106
27. Other Revenue (specify):	-6,566
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-6,566
30. Total Revenue	5,048,845
31. General Services	1,111,519
32. Health Care	2,285,808
33. General Administration	1,225,928
34. Ownership	250,605
35. Special Cost Centers35. Provider Participation Fee	143,682 48,728
37. Other	40,720
40. Total Expenses	5,066,270
41. Income Before Income Taxes	-17,425
42. Income Taxes	0
43. Net Income or Loss for the Year	-17,425

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